OPEN ACCESS Freely available online

General Medicine: Open Access

Review Article

The Need to Reinsert Subjectivity in Medical Care

Felipe Rilova Salazar*

Department of Medical Bureau, Office of Domestic Violence, Supreme Court of Justice, Argentine Republic

ABSTRACT

Without ignoring the warm and prudent style that many doctors can radiate individually in the treatment they provide to their patients, the truth is that this bioethical concern is not consistent with the prevalent positivist matrices that sustain medicine as a social institution. As we will see, the discourse of a discipline is the linguistic form in which knowledge is exposed. The words that a speech reiterates (its vocabulary) reflect both the way of "saying" and that of "thinking". In order to the absence of terms referring to subjectivity in medical discourse, we will take care to point out the healthcare consequences that depend on this conceptual exclusion.

When the object of a science is also a subject, disregarding considerations related to this aspect carries significant clinical risks. Reinserting the subject in care, leaving the exclusive objectification, prevents the medicine from causing the same thing that it intends to treat.

Keywords: Bioethics; Medicine; Medical discourse; Metaphors; Therapeutic weapons

INTRODUCTION

As a mental representation, the idea of disease usually causes associations such as “abnormality“, “dysfunction“, “illness“, “failure“ or “attack“. The different perspectives given to disease by our culture at different moments of history are displayed, in our current medical speech, as different lenses of the same telescope. The lenses of that telescope are a result of the crystallization, at the conceptual level, of the many times they have been prevailing circumstances at the factual level. Thus, the fact that diseases are nowadays referred to in war terms, is not oblivious of the fact that since the early 20th century man has killed more human beings in wars than in the rest of the history.

We talk about “attacks” (heart, asthma and gout), “therapeutic weapons”, “drug arsenal”, “vaccination campaign” and “cobalt bomb” as powerful “allies” to “fight” diseases. Moreover, therapeutic efforts are collected in “fight leagues” set up “against” them. On the same line, anatomic structures such as the “sentinel node” lie inside our bodies occupying the first line in the “defense” against a possible “tumor invasion”. In other circumstances “septic invasions or shocks” may occur and the institutional professionals in charge of fighting these conditions are “corporals” who are nurses and doctors “on duty”, supervised by the “chiefs” of different departments, subordinate, in turn, to “heads of department”, who are those “high rank” doctors to whom the doctors on duty respond to War metaphors.

According to Lacan who in turn is inspired by Heidegger–we speak and we are spoken since we are speakers of a social discourse.

The discourse in a discipline medicine, in this case preannounces the way in which that discipline will influence the way to deal with the concrete events that it intends to solve. At this point, we should remember that the ideals of time and reality themselves are a “social construction” in continuous development [1].

In the following pages, we are going to examine the times in which the different terms and metaphors we acknowledge in the current Medical Discourse (MD) are being added because many criteria are crystallized in a lexicon that allows us to recognize what the MD praises (what is visible, material, the generic features: The object) and what it dismisses (what is invisible, unsubstantial, the singular: The subject).

The study of the medical terms that academic publications and dissertations use to refer to disease allows us to clear a well-stocked ideological padding coming from different sources that

Correspondence to: Felipe Rilova Salazar, Department of Medical Bureau, Office of Domestic Violence, Supreme Court of Justice, Argentine Republic, E-mail: frilova@csjn.gov.ar

Received: May 03, 2021; **Accepted**: May 17, 2021; **Published**: May 24, 2021

Citation: Salazar FR (2021) The Need to Reinsert Subjectivity in Medical Care. Gen Med (Los Angeles). 9: 338.

is, notwithstanding, compatible with and related to war metaphors.

Ideologically figuring out the MD we may be able to recognize the different analysis categories to which disease is subjected, reach the ground of social and academic beliefs that provide the basis for the directionality of many researches and the way in which this directionality conditions its results as well as its way of developing the therapeutics that depends on the social bond that the MD sets forth.

In a crossroad of discourses of different nature, we will be interested in analyzing the Disciplinary Discourse (DD) in its internal relation with the ideological discourse (bound to the exclusive medical view) and in its external relationship with the personal discourse: The Patient's Discourse (the PD) (only available through the Medical Listening (ML)).

The MD expresses what disease means to the scientific consensus, while the PD communicates what being ill means to the patient, hence the medical view and listening are meant to find a way to articulate in assistance.

Attentive to the fact that not taking subjectivity into account results in unhealthy consequences, we will emphasize the need to reinsert the subject in assistance by Medical Listening bearing in mind that: Listening does not mean inquiring; listening is, first of all, an attitude that is shown through gestures that make the other person know that we have a place for them inside ourselves.

DEFINITION AND TYPES OF DISCOURSE

Discourse is the linguistic form in which knowledge is presented. Words that make up discourse (vocabulary) reveal the way of reasoning (thinking) as well as the model of thinking (or paradigm) that serves as a stable framework for that discursive activity.

The term discourse then refers to words as well as concepts, to "saying" as well as "thinking". According to the agent that pronounces it, the environment in which it appears or the purpose it serves, a discourse may be disciplinary (e.g. "Medical Discourse), ideological (e.g. "the group of ideas or concepts that support medicine in its task") or personal ("the words that someone (a subject) uses to express his feeling or thinking").

In this crossroad of different discourses, we have already said that we are being delayed in considering a disciplinary discourse: The Medical Discourse (MD) in its internal relationship with the ideological matrixes that condition it and in its external relationship with the patients' discourse and their environment.

IDEAS AND BELIEFS OF A DISCOURSE

The hypothesis and ideas that a discourse presents constitute its products. These "ideas" are the specific sprouts that a discourse fertilizes when it develops. However, the manufacture of "ideas" (always incomplete and unstable) requires firm ground to settle on. This is why; ultimately through the "ideas" of the discourse, you can acknowledge the "beliefs" that support it. Every discourse arises from the similarity of a group of ideas and beliefs and, that way, from the sprout ideas you can get to the ground of beliefs in which every discourse has its roots.

According to Ortega Y Gasset's thinking, we "have" ideas but we find ourselves "placed in" our beliefs. For this author, "beliefs" would be a particular type of ideas that are usually exempt from critic since we are not the ones who support the "beliefs" but "they" are the ones that support us. Therefore, "beliefs" would be the ground of basic assumptions on which we support. We are placed on them and we plant firmly on them. That is why beliefs refer to matters that repeat themselves and seem so obvious to us, such as the flooring on which our feet are standing. That is the case, for example, of the firm epistemological and social belief of a categorical division between body and soul and its consequent possibility of considering them separately. The life of society usually supports itself on this kind of ideological fantasy that is regarded as objective truths, while there are countless cases in which there are clear facts that can dismiss those presenting elements that can question the ground of beliefs that sustain us.

"These basic 'ideas' I call 'beliefs' do not arise at a certain date and time within our life. We do not get to them by a particular act of thinking. They are not, in short, thoughts that we have, they are not even notions of that species elevated by its logical perfection that we call reasoning. On the contrary, these ideas that truly are 'beliefs' constitute the continent of our life and, therefore, they do not have the nature of particular contents in our lives. It should be said that they are not ideas we have but ideas we are. Even more, precisely because they are very radical beliefs, we confuse them with reality itself."

THE CONCEPT OF DISEASE AS A SOCIAL INSTITUTION

Thus, the disease has been prevailingly an "evil" for the European medieval logic; a "failure" or "dysfunction" for the mechanistic criteria of western modernity; an "abnormality" for the positivist normativism and the industrial revolution; and an "attack" since the great wars of the 20th century.

From the philosophical point of view, the dualist and mechanistic line of modernity can be recognized in names such as "respiratory system" or "defense mechanisms" as well as in the criteria that tend to consider the body a group of parts that can be replaced. This set of ideas gave rise to powerful metaphors such as those that depend on the categorical division between body and soul or those that compare the human body with a machine whose constituting parts emulate the functions of a clock:

"I think of the human body as a machine – René Descartes wrote in his last work-From my thinking, the idea of a healthy man and a well-made clock is comparable to the idea of an ill man and a badly made clock" [2].

The comparison with "that prodigious machine that marked the beat of the time."

was translated in a concrete attitude that "started to transfer its beats, its regularity and its precision to the bodies and routines of men" [3].

The consideration of the body as a group of inert parts confuses human disease with the random failure of one of its parts or organs, being the cure its repair, extirpation, or transplant, without taking into account well enough the convenient time according to the subjective time and the quality of the background of the subject that will undergo surgery.

In the field of biology, they usually talk more appropriately about organisms and they pay special attention to the "levels of integration". Thus, the brain or the liver, linked to prevailingly nervous or digestive functions, are determined by a mutuality of influences that form interdependent vital groups that are not considered as separated parts. In biology, a particular organism may be described by the parts that form it but, taking into account that those parts work independently, that consideration contrasts with the criteria that frequently dismiss this interdependent character falling into standardization of interchangeable parts and organs as an expression of the mechanistic criteria that still prevail in the discourse of contemporary medicine.

Unlike what happens with the mechanistic lexicon and the general ideological canons of Western Modernity, there are other terms that also persist in the medical discourse notwithstanding its origin in a much more remote significance. Thus, for example, the word "incubation" comes from the term "incubus" (Latin): In the Middle Ages, it was the male demon that possessed the sinner while he was sleeping. "The languages are full of fossils that no longer contribute to the world of speakers" [4].

In every member of society not withstanding his condition of layman or academic there is an heir and a bearer of a large cultural history that is sometimes unknown to him. The keeper of that history is language we refer to the mode of expression typical of every community, considering that language is not only the expression of things but also a force that operates on things, imposing on them its limitations and rules.

According to the limitations that depend on its theoretical vocabulary, as at today medicine does not count on terms that could convey some elementary considerations about human subjectivity. Linguistic and logical instruments gathered by medicine do not come to terms with this consideration. This linguistic and cultural influence constitutes a primary aspect to be considered when providing a healthier assistential practice. We think in terms of "psychic" and "somatic" or "mental health" and "physical health" and our academic areas are categorically divided according to this conception even when in reality things happen differently. When Doctor Florencio Escardó suggested, during the period he was Chief of Ward 17 of the "Buenos Aires Children's Hospital", that children should be hospitalized with their mothers, that suggestion, which many presumed linked to the mental health of the children, also reduced the period of convalescence and even the mortality of children affected by organic pathologies.

More than 70 years have passed since the implementation of that experience. Since then, the hospitalization of the mother with her somatically ill children still holds, despite the fact that the general depersonalization of medical assistance has continued deepening.

It is true that, over time, many times many terms do not longer mean the same. Today we no longer relate an epileptic "seizure" with the wrath of the gods nor do we think that "incubations" constitute an expression of hardened hostility from them to human beings.

When approaching the real situation of the person who is ill, nobody gets to know exactly where the "evil", the "failures", the "attacks" or the "deviations from the rules" are.

When revising the metaphors of the medical discourse, it draws attention to the coexistence, within the same discourse, of terms of such a diverse origin and sense. But these words are not conceptual wastes or sediments that accumulate over time by mere sedimentation. Accordingly, it is necessary to acknowledge that in the lexicon of current medicine, not any "linguistic fossil" remains. The metaphors of medical discourse do not agree on what they assert but on what they silence, in such a way that its terms are selected according to precise negative or exclusion criteria, where the metaphors selected avoid any allusion to the integral condition of the person who is suffering.

The history of science is not "a succession of chances". The constitutive elements of medical discourse agree on certain governing interests that, while not connected to health, are the ones that justify the persistence of so dissimilar linguistic components [5].

The remaining "linguistic fossils" are those that meet the requirement of not questioning the fundamental ideological structure of the current medical paradigm. That is why the "evil", the "failure", the "seizure" or the "attack" can coexist in the same discourse; because the tacit agreement of the medical discourse lies in the exclusion of the patients' subjectivity and any term that may make reference to it. Disease, therefore, has to be the effect of some germ or any other type of agent or substance that is not connected to or is external to the person who suffers it. Medical discourse does not deal with anything else.

The logical consistency of medical discourse is not given then by what it says but by what it traditionally omits. The "seizures", the "attacks", the "failures" do not coincide in their origins or what they express; the intimate similarity of these terms lies in what they fail to express: None of them makes reference to specifically human matters. This way, the so-called disease is not something that can follow sadness, the lack of horizons, or processes such as margination. These omissions, therefore, constitute the structuring core and the negative organizer of medical discourse.

You can "fight" tumors, "attack" bacteria, or influence with some chemical substance on the functioning of this or that "system" without the person of the patient being involved in all that process. In their apparent diversity, medical discourse metaphors agree on not collecting terms linked to the

subjectivity or the bonds of the patient because, according to the ideological direction that medicine as a social institution imposes, the subject as such is left out of all consideration by the MD, is left out of the huge efforts that health professionals can make trying to go a little further than their training discourse.

ALEXITHYMIA

By 1973 the Bostonian physician Peter Sifneos proposed the term "alexithymia" (from the Greek: Lack of words to verbalize affection) to describe personality traits of patients prone to develop somatic disorders which were serious, early and frequent. Sifneos referred to "primary" alexithymia, when that disorder appeared as a stable characteristic of the personality, and "secondary" alexithymia, when it was the result of an overload of events that overflew the expressive possibilities of the individual facing certain extraordinary circumstances [6].

With no reference to a specific personality trait, a research by Petrich and Holmes provided results that allowed them to state that, in the presence of an overload of vital events that overlap in time, an illness may develop making the human being vulnerable to be affected by an organic disorder in such circumstances. The work "Life change and onset of illness" resorts to a self-administered survey in which they record events capable of having caused a recent change in the life of the survey respondents [7]. Developed from a series of empirical observations, the research had the support of the University of Washington. This research awarded a score to the vital events that could have accumulated in the period prior to the onset of an organic illness. The survey granted a variable score (life change units: "LCUs") according to the magnitude of the vital changes that followed certain events. This way they added the points they deemed appropriate to various events. A slight change in the hours of sleep had a very slow score, a change of job a much higher score, but the score assigned to getting married or to suddenly winning a great amount of money in the lottery scored as many "LCUs" as marital separation or as being found guilty in a criminal process with a jail sentence. 43 items were listed in the initial work. To determine the score of the survey the points added were divided by a unit of time of 12 months and an inverse proportion was used: the lower the period of time in which the sum of events occurred, the higher the score computed by the survey.

The simplicity of the study allowed its large-scale implementation and the revision of this work gave rise to other 72 publications in which the same survey was applied. According to the results of these researches, 80% of the people who got ill had accumulated more than 300 "life change units" in the last twelve months and 50% of the people who got ill had accumulated between 150 and 300 "LCUs", establishing a direct relationship between the magnitude of the changes and the seriousness of the illness.

Clearly, the survey must adjust the considered items according to the characteristics of the groups it assesses; but taking into account the thousands of cases researched, the value of the study cannot be dismissed. Strikingly, in the questionnaire of Petrich and Holmes, the life change units related to medical treatments per se are stated in an indirect and brief way; for example, the score resulting from a period of several days of hospitalization in an intensive care unit. This must probably be related to the alexithymia condition of the medical discourse in itself.

Another research that confronts us again with aspects still unknown by the organic logic was carried out in our field more than 30 years ago. Targeted to patients who had undergone a kidney transplant, the study showed the close existing relationship between the bond donor-recipient and the organ acceptance or rejection [8]. The kidney transplant has the peculiarity that the donor and the recipient usually know each other since they are live donors who frequently are first-degree relatives. For five years they followed up the alternatives of the donor-recipient bond in 20 couples. The results of the research showed that when bonding problems arose between the recipient and the donor, an immunological rejection to the transplant appeared, objectified by a rise in creatinine levels.

The authors of this research tried to objectify the bonding problems using a test developed by Raúl Usandivaras, specially designed for the study of the relationship between two individuals. With these materials, concurrently with the immunosuppressant treatment, they tried to deal with the bonding problems, and the improvement in the interpersonal relationship coincided with the decrease in the rejection indexes. This study was published and was awarded prizes but, to date, there have been no changes regarding the psycho prophylaxis of patients receiving a kidney transplant.

We have already seen that doctors lack an appropriate vocabulary regarding the communication of the emotional states of their patients. Medicine, as a social institution, does not show a commitment with a language other than the one that allows the description of "objects", and the cold objective description can be the pretext to not approach those emotions that affect us daily.

"We all tend to somatize every time certain circumstances overpass our usual ways of resistance" [9].

According to Samil Alí, a psychoanalyst of Egyptian origin, "when you cannot even dream the way out of a crisis, you should seriously fear an organic disease" [10]. Equally, the physician Pedro Lain Entralgo does not hesitate to say that dispensing with the indication of psychotherapy "as a result of negligence or rush, may in certain cases be an ethical neglect as serious as forgetting to check pupillary reflexes in other cases" [11].

The alleged deficit of interhemispheric communication in psychosomatic patients is, to date, just a hypothesis of Sifneos that has not found an echo in the thoughts of other authors. In relation with psychosomatic patients, it is necessary to integrate the contributions coming from the disciplinary hemispheres that are not communicating with each other.

The study of the coincidence between the difficulties for subjective expression of emotions and the increase in organic illnesses gave rise to the foundation of the Paris Psychosomatic School, where they stated other precisions regarding the psychological traits presented in people with a tendency to

organic pathologies. Since then, they started to refer to patients with an "over adapted" personality [12]. They recognized in them the predominance of a particular type of thought, poor in fantasies that came to be called "operational thought". This "thought" makes reference to the insufficient mentalization of emotional states in coincidence with an activity mainly organized for social adaptation and performance. Far from solving their problems, these individuals have no alternative but to adapt themselves they over adapt to the situations they face, and their behavior is locked within socialized formulas. Moved by strict ideals, the over adapted patients are forced to submit themselves to all kinds of demand, being the "organic disease" the common final result of this way of development where, behind apparent psychic normality, there would be a "disability" for introspection and expression of oneself.

The psychoanalyst coined the term "normopaths" for those patients who are not able to pronounce "the word" or to build a "psychic image" that would allow them to communicate emotionally with themselves and with others [13].

In one of his first written works, Freud asserted that "affections, and almost exclusively depressive affections, very frequently turn into pathogenic causes for nervous system diseases with recordable anatomic alterations as well as diseases of other organ. There is no doubt that life expectancy may be remarkably shortened by depressive affections. It is evident he adds that great affection has a lot to do with the resistance capacity to infection. Soldiers who get ill are those who belong to the defeated army" [14].

Between its main theoretical instruments, Freudian works developed by 1905 the notion of pulsion (from the Latin verb pulsare: Push, drive) as a limit concept between somatic and psychic. Initially, he considered this notion to be integrated by 3 elements: A source, an object and, an aim [15].

The "object" real or fantasized is the most variable element of pulsion and is determined by the singularity of each subject according to his history [16].

The "aim" is the discharge always partial of the tension coming from the source.

By 1915 Freud introduced the fourth component: The "drive", in reference to the quantitative aspect of pulsion. The drive sets in motion the actions that it promotes to fulfill its "aims" [17].

For the psychoanalysts psychosomatic patients would be those in whom the energy of pulsion is aborted in the "source" when it is not linked to the "object" that would allow the pulsion discharge [18]. The difficulty to find their own objects would date back to past deficiencies, linked to merely administrative early care.

The disease, the object of the body, comes to take the place of a psychic object that is missing: The object of the pulsion. If the energy of the pulsion is able to link with the representations of its object, in that occasional event the pulsional energetic quantum is qualified and turned into affection ("thymos") and the representation of that object in significant words ("lexis"), which, in turn, results in a reversion of the alexithymic condition.

The development of the subjective ability for the sensory qualification of perceptions operates based on the accurate deliveries that the original "ego-reality" receives from the world in response to the expression of those misgivings lacking a subject [19]. The pertinent environmental attentions contribute to a progressive constitution of the subjectivity and to the concomitant development of the ability to feel one's own feelings, based on the "identifications" operated in the original ego when this ego feels felt by those on which it depends during his early defenselessness stage [20].

The initial bawls that the infant casts over the world when they are empathically decoded by the members of his environment return to the child through gestures and concrete operations that allow the possibility of a stable "identification" with those empathic bonds. "Identification is not a behavioral category: It is an unconscious mechanism that produces lasting modifications in the subject" [21,22].

These essential bawls uttered by the "infans" (speechless), due to undifferentiated tensions and perceptions, may be able to be qualified if they return to the child like specific actions coming from an empathic mother who is able to establish a differential register of those bawls. She will be able to differentiate if the child's discomfort is caused by hunger or cold or if that crying is an expression of the pain caused by a diaper rash. Then, based on the specific actions the mother performs to alleviate each one of those tensions (breastfeeding in the first case, wrapping him up warm in the second case, and changing diapers in the third case), the child starts to develop an initial conscience that will progressively allow a sensory qualification of the perceptions undifferentiated until then, as a result of the identification with that empathic and affective mother.

In what could be a great scale expression referred to the impossibility of sensory translation related to deficiencies in the environment, we have dealt with "undifferentiated coding" of colors in different tribal communities pointing out that, from the neurophysiological point of view, there is not a qualitative distinction of the chromatic signs sent from the sense organs to the brain when there is no previous cultural instruction. Evoked potential studies performed on the visual field allowed to confirm that the receivers, who would supposedly perceive a certain color, do not emit a signal when they lack cultural information regarding that hue. The opposite happens with the qualitative assessment that the Bedouins from the desert can make regarding the different kinds of sand or that the Eskimos can make regarding the different kinds of snow that they are able to recognize.

In the field of individual processes and regarding the ability to register one's own "feeling", the early bonding precariousness, related to the affectionate dismissal of the environment, deprives the human infant of the minimum identificatory support on the base of which he could be able to translate his undifferentiated perceptions into sensory qualities, developing, at the same time, the ability to feel his own feelings.

The treatment that tries to revert this subjective inability to connect somatic energies with psychic objects is a task that will require complex and highly prepared training. However, in

relation to this issue, the general practitioner, through his practice, has a relevant function that depends on not imposing an excess of stimuli that may result structuring nor an apathetic disconnection that may promote over adaptation or that may aggravate a preexisting alexithymia condition.

Many psychosomatic disasters that depend on medical interventions relate to the automatic and rash application of the rules of "principialistic bioethics" [22].Thus, for example, the "right" of the patient to know the truth this rule is connected to the "Principle of Autonomy" of the principialist bioethical current should not be confused with the "obligation" the patient has to know the whole spectrum of possible complications regarding his condition, even when they are very unlikely contingencies.

The simple contemplation of an X-ray, taken as a look that reveals the surface of the body and intrusively catches a piece of its insides, may become a devastating operation when, based on it, possible ominous evolutions are automatically communicated, omitting to consider the impact it might have on the receiver of such communication.

The alternative to this possible subjective wreck is not a medical lie nor a return to paternalism but the assessment of how much each patient can handle and needs to know regarding his condition at the time, considering the possibility of summoning the people who are closer to him to share with them the deliberations of the matter. In order not to fall into "bioethical" reckless automatisms, it is advisable to check the proposals of the "Principialistic Bioethics" in the approach that highlights the responsibility to consider what every patient wants and needs to know about his condition, as the "Personalistic Bioethics" current suggests, whose main example is Elio Sgreccia [23].

According to her huge experience regarding the matter of communication of ill-fated prognosis, when specifically referring to the matter of "hope", Dra. Elizabeth Kübler Ross does not hesitate to assert that the loss of hope results incompatible with the continuation of life.

"In listening to our terminally ill patients we were always impressed that even the most accepting, the most realistic patients left the possibility open for some cure, for the discovery of a new drug or the "last-minute success". No matter what we call it, we found that all our patients maintained a little bit of it and were nourished by it in especially difficult times. They showed the greatest confidence in the doctors who allowed for such hope. If a patient stops expressing hope, it is usually a sign of imminent death. All these patients died within twenty-four hours" [24].

Without getting to the devastating wreck of hope due to wild communications, if the person of the doctor blurs and if in his involvement he is reduced to a mere handler of techniques, from then on an alexithymia atmosphere sets in that makes his interventions end up causing or aggravating what he intends to treat or cure.

A historic example of vital collapse due to bonding precariousness is that of the experience of emotional deprivation carried out by Frederick II, Emperor of the Holy Roman German Empire between 1190 and 1250, who was moved to discover which was the natural language in human beings this "experiment" is recorded in [25]. For that purpose, the Emperor took a large number of newborns it is said that a total of forty neonate they were given to foster mothers so that they would provide them with the administrative needs eating, dressing and hygiene with the instruction not to communicate with the newborns in any way. Living sumptuously, the experience ended shortly with the death of all the infants subject to this experiment. "Deprived of the bath of language – the language of caresses, lullabies, whispers and looks no baby survived" [26] . After Freud, it was Lacan who cleared the terms in which the subject, the object and the "Other" relate, which takes us to recognize that the affection of every person only becomes such when there is Other who assists him as such; that is, according to his dignity [27].

We are interested in considering, very especially, the specular imprisonment to which a "subject" is confined when he is surrounded by "others" than only recognize him as an "object". Let's think about someone in his right mind who suddenly loses part of his autonomy as a result of a mild cerebrovascular accident. The sum of limitations that person unexpectedly suffers starts awakening in him an intimate feeling of estrangement and insignificance. Separated from his family and with the new neurological dysfunctions, when he regains consciousness he finds himself in the Intensive Care Unit in which he has been hospitalized without his consent and where he receives an impersonal treatment that increases the feeling of estrangement and insignificance that he has begun to feel with respect to himself.

Who is the subject to be called in these cases as the bearer of the source of the "pulsion to cure" since, according to the changes he suffered and everything that the environment gives him back at that time, that subject does no longer recognize himself as such [28,29]?

The psychoanalyst David Maldavsky refers to the essential place that the doctor, no matter his specialty, as a neighbor may take when life itself is seriously threatened:

"In the economic effort to neutralize the tendency to let yourself die, it is important to have criteria to figure out the pulsional vitality of the other to proceed to respond in a similar way, in the sense of the generation of a tension accompanied by its corresponding complexity and differentiation. I would say that a click would be necessary, a process created on the understanding of the vital tension of the other and that sometimes patients pretend to figure out when looking deep into the eyes of their interlocutor" [29].

CONCLUSION

The alleged interhemispheric communication deficit is to date just a hypothesis of Sifneos that has not found an important echo in the thought of other authors. But regarding the coincidence between difficulties to express oneself and a higher index of disorders, there exists a multiplicity of opinions that agree with this aspect. In this work, we have devoted ourselves to

consider the need to reinsert the subject in assistance, which implies the intention to buffer the alexithymic condition of medical discourse through listening.

"The physician asserted physiologist Claude Bernard in one of his works is frequently forced in his treatments to bear in mind what is called the influence of moral over physical facts and, therefore, a multiplicity of considerations about family or social status"

However, sometime after Claude Bernard, it was the philosophy of the interests of the time that marked medicine and not the other way around. In proxemics terms, it is not about shortening the distance with the patient towards an intimate level. In no way this is about intimism but about shortening the social distance that prevails in medical attention trying to establish a personal bond between the assisted and the assistant, which implies calling the person by his name at all times, being able to know if he feels prepared to face certain exam or certain intervention and, above all, listening. Listening does not mean inquiring; listening is, first of all, an attitude that is shown through gestures that make the other person know that we have a place for them inside ourselves.

The task requires a joint reflection and a wise dynamic balance, oriented to state the optimum distance to be held during the different moments of assistance that the patient goes through. If this bioethical reflection does not take place, the social attempts to reinsert the subject in assistance will surely continue to appear but their social attire will probably be the loss of prestige.

The responsibility to enrich medical discourse does not entirely fall on medicine but also on other disciplines that, having so much to offer, they, nevertheless, lock themselves up in their respective theoretical ghettos. In this sense, not only those who do not verbalize their affections properly would become ill but also the social institutions that do not cooperate, in transdisciplinary terms, to alleviate this situation. In the words of the famous medical historian Pedro Lain Entralgo "Medicine is, or should have always been, one way or another, psychosomatic; pathology not always."

REFERENCES

1. Berger P, Lukmann T. The Social Construction of Reality, 1991. p: 41.
2. Descartes R. The Passions of the Soul. Editorial Aguilar (4th edn). BuenosAires, 1821. p: 46.
3. Sibilia P. The Post Organic Man: Body, Subjectivity and Digital Technologies Fund of Economic Culture, Subjectivity and Digital Technologies Fund of Economic Culture, Buenos Aires, 2005. p: 72.
4. Rodriguez A. Structural Linguistics. Editorial Gredos Hispanic Romance Library. Madrid, 1969. p: 863.
5. Lecourt D. Introductory Prologue to the Book: The Normal and the Pathological by Georges Canguilhem. Siglo (21st edn) Buenos Aires, 1986. p: 14.
6. Sifneos P. The Prevalence of Alexithymic Characteristics in Psycho-Somatic Patients- Psychoterapic and Psychosomatics. 1973. pp: 255-262.
7. Loudet O. Philosophy and Medicine. Emece Editores. Argentina, 1977. p: 83.
8. Bujaldón M , M.I Giacoletto de Allemand S. The Receptor Donor Link in Kidney Transplantation. Coca Cola Award for the Sciences and the Arts. 1985.
9. Mcdougall J. Op.Cit. 1991. p: 13.
10. Sami A. Thinking the Somatic Paidos. Buenos Aires, 1994. p: 72.
11. Lain Entralgo P . The Doctor and the Sick. Guadarrama Editions S. A. Madrid, 1969. p: 173.
12. Marty P. The Psychosomatic of the Adult. Amorrortu. Buenos Aires, 1982.
13. Mcdougall J. Theaters of the Body by Julián Yébenes. Madrid, 1991. p: 36.
14. Freud S. Psychic Treatment-Treatment of the Soul. Volume 1. Amorrortu Editores, 1988. p: 119.
15. Freud S. Three Essays on a Sexual Theory Volume 7. Amorrortu Editores, Buenos Aires, Argentina, 1988.
16. Saurí, Jorge J. History of Psychiatric Ideas (First part, Carlos Lohlé edn.) Buenos Aires, Mexico, 1969. p: 42.
17. Freud S. The Drives and their Destinations. Volume 14. Amorrortu Editores, Buenos Aires, 1988.
18. Kury J. and Pérez C. Developments in Psychoanalytic Psychopathology. (Editorial Letra Viva), Buenos Aires, 1983. p:187.
19. Freud S. The Drives and their Destinations. Volume 14. Amorrortu Editores, Buenos Aires, 1988. p: 129.
20. Maldavsky D. Nightmares in Vigil. Amorrortu Editores, Buenos Aires, Argentina, 1994. p: 129.
21. Grinberg L. Identification Theory. Tenipublicaciones, S.A. Madrid Spain, 1985. p: 8.
22. Beauchamp L & Childress J. Principles of Biomedical Ethics. Masson, Barcelona, 1999.
23. Sgreccia E. Bioethics Manual. Volume 1. Editorial BAC, Madrid, 2014. p: 183.
24. Kübler R, Elizabeth. On Death and the Dying. Ediciones Grijalbo. S.A. Barcelona, 1993. pp: 180-181.
25. Rof Carballo J. Biology and Psychoanalysis. Desclee de Brower Bilbao, 1972. p: 182.
26. Galbiati A. Medical Discourse, Science and the Talking-Cure in L'Evolution Psychistrique. Volume 61, 1996. pp: 921-936.
27. Lacan J. The Self in Freud's Theory and Psychoanalytic Technique: Introduction of the Big Other, The Seminary. Paidós, Buenos Aires, 1983. p: 353.
28. Freud S. Conference 32. Volume 22, Amorrortu Editores, Buenos Aires, Argentina, 1988. p: 98.
29. Maldavsky D. Nightmares in Vigil. Amorrortu Editores, Buenos Aires, 1994. p:178.